ADDITIONAL INFORMATION REQUEST

CLIENT NUMBER ______________________ STATEMENT DATE ________________________

If charges should be changed to Bill Patient, Medicare, Medicaid or other insurance fill in and return the information below. Please include a copy of the statement pages for which you are requesting credit. Credits can only be requested for thirty (30) days after receipt of bill.

SSN: _____________________ PATIENT NAME ___________________________________ DATE OF SERVICE _______________________

Street ____

City _________________________________ State _______________________ Zip ____________________

*Date of Birth _______________ *Diagnosis/ICD-9 ____________________ Sex ______________

*Ordering Physician ____

Medicare ID# _____________________________ Medicaid ID # ___________________ State __________________

Ins. Carrier _________________________________ Group # _____________ ID # ___________________

Effective date of insurance ___________________ to ____________________

Ins. Carrier Address _______________________________________ Employer Name ____

Subscriber ___________________________________ Relationship ____
(IF DIFFERENT FROM PATIENT) (RELATIONSHIP OF SUBSCRIBER TO PATIENT)

Champus: Sponsor Name _____________________________ Sponsor SSN _________________ Rank _______________ Branch __________

SSN: _____________________ PATIENT NAME ___________________________________ DATE OF SERVICE _______________________

Street ____

City _________________________________ State _______________________ Zip ____________________

*Date of Birth _______________ *Diagnosis/ICD-9 ____________________ Sex ______________

*Ordering Physician ____

Medicare ID# _____________________________ Medicaid ID # ___________________ State __________________

Ins. Carrier _________________________________ Group # _____________ ID # ___________________

Effective date of insurance ___________________ to ____________________

Ins. Carrier Address _______________________________________ Employer Name ____

Subscriber ___________________________________ Relationship ____
(IF DIFFERENT FROM PATIENT) (RELATIONSHIP OF SUBSCRIBER TO PATIENT)

Champus: Sponsor Name _____________________________ Sponsor SSN _________________ Rank _______________ Branch __________

SSN: _____________________ PATIENT NAME ___________________________________ DATE OF SERVICE _______________________

Street ____

City _________________________________ State _______________________ Zip ____________________

*Date of Birth _______________ *Diagnosis/ICD-9 ____________________ Sex ______________

*Ordering Physician ____

Medicare ID# _____________________________ Medicaid ID # ___________________ State __________________

Ins. Carrier _________________________________ Group # _____________ ID # ___________________

Effective date of insurance ___________________ to ____________________

Ins. Carrier Address _______________________________________ Employer Name ____

Subscriber ___________________________________ Relationship ____
(IF DIFFERENT FROM PATIENT) (RELATIONSHIP OF SUBSCRIBER TO PATIENT)

Champus: Sponsor Name _____________________________ Sponsor SSN _________________ Rank _______________ Branch __________

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*(REQUIRED FOR ALL INSURANCE CARRIERS)

***Physician's or designee's signature is required in order for credit to be given for the above patients.

***Physician or designee signature: ____ Phone # _________________